



# International Conference

on Research, Health Care and Preventive Measures  
for Female Genital Mutilation/Cutting  
and The Strengthening of Leadership and Research in Africa





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## Conference Report

17-19 October 2011  
Nairobi, Kenya





*"It is hoped that this document will serve not only as a source of information but also as a call to address the increasingly global problem of FGM/C - a practice that poses a serious risk to the physical and mental well-being of millions of women and young girls. The effort must reflect the diversity of the various nations and cultures in which this practice is carried out. It must focus on capacity-building and the crucial sharing of information."*

**Professor Joseph G. Karanja**

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# List of abbreviations and acronyms

<b>ACHPR</b>	African Centre for Human and People's Rights
<b>ARP</b>	Alternative Rites of Passage
<b>CEDAW</b>	Convention on the Elimination of All Types of Discrimination against Women
<b>DHS</b>	Demographic and Health Survey
<b>FGM/C</b>	Female genital mutilation/cutting
<b>FIDA</b>	Federation of Women Lawyers - Kenya
<b>HIV</b>	Human immunodeficiency virus
<b>ICRH</b>	International Centre for Reproductive Health
<b>NGO</b>	Non-governmental organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UoN</b>	University of Nairobi
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization
<b>WHO/HRP</b>	World Health Organization/Research and Training in Human Reproduction

# Foreword

This report provides an account of the International Conference on Research, Health Care and Preventive Measures for Female Genital Mutilation/Cutting and Support for Capacity Strengthening of Leadership and Research in Africa, held on 17-19 October 2011 in Nairobi, Kenya. The event was hosted by the University of Nairobi and sponsored by the United Nations Population Fund (UNFPA) and the University of Sydney, Australia. The World Health Organization/Research and Training in Human Reproduction (WHO/HRP) and the International Centre of Reproductive Health (ICRH) - Ghent University (Belgium), provided key technical support to the conference. Other collaborating organizations were the United States Agency for International Development (USAID), and the University of Washington (Seattle, Washington, USA).

Significant in several ways, the conference first provided an opportunity for those working across a range of fields towards ending female genital mutilation/cutting (FGM/C) to share their experiences. Second, the many participants indicated that it is no longer an issue to be addressed only within Africa; rather, it is crucial for those in African countries to work more closely with those from other regions and countries to share and learn from one another's efforts. Last, the conference provided an opportunity to explore the possibility of establishing an African Coordinating Centre for the Elimination of FGM/C, as proposed by the University of Nairobi.

Participants identified gaps in research, policies, current interventions, monitoring and evaluation. They viewed the establishment of the proposed coordinating centre as a strategic and much needed action to address those gaps and support collaboration across the field. In particular, they viewed the proposed centre as a positive step in addressing the language barrier among campaigners in anglo-phone, francophone and Arabic-speaking nations.

We, at the University of Nairobi, wish to reaffirm our commitment to the establishment of the African Coordinating Centre. We thank all those who attended the conference as well as the institutions and organizations that contributed so much time, energy and expertise to ensuring its success. We are especially grateful to UNFPA and the University of Sydney for their generous sponsorship of this conference.



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*Participants at the International Conference on Research, Health Care and Preventive Measures for Female Genital Mutilations/Cutting and the Strengthening of Leadership and Research in Africa, held in Nairobi. The Conference was attended by the Honourable Linah Jebii Kilimo, Assistant Minister for Cooperative Development and Chair of the Kenya Women Parliamentary Association, by Professor George A.O. Magoha, Vice-Chancellor, University of Nairobi, and by Mr Paul Dziatkowiec, Deputy High Commissioner, Australian High Commission.*

## *I. Introduction*



**F**emale genital mutilation/cutting (FGM/C) is a deeply rooted and widely supported cultural practice in 28 countries in Africa and some countries in Western Asia and Asia, and among immigrants from these areas in Europe, North America and Australia, according to the World Health Organization (WHO).

United Nations Resolution 54/7 of the Commission on the Status of Women (2010) states that ending FGM/C worldwide requires a multidisciplinary, comprehensive, coordinated and coherent approach at all levels in recognition of the fact that it operates as a social norm. Some of the reasons given to sustain the practice include perceived religious and cultural obligations, family honour and the preservation of virginity as a prerequisite for marriage.<sup>1</sup>

Momentum is building all over Africa for the elimination of FGM/C. However, evidence is needed for the continual implementation of strategies and approaches in this effort. For instance, information on the health consequences is scant. There is also a need for data to facilitate monitoring and evaluating progress. Additionally, capacity-building is required to create synergies among various approaches towards the elimination of FGM/C and to monitor the influence of research and interventions on policies.

### **A. Purpose of the conference**

Recognizing these needs, the University of Nairobi (UON) partnered with the United Nations Population Fund (UNFPA), WHO, the International Centre for Reproductive Health (ICRH) at Ghent University, and the University of

.....  
<sup>1</sup> See, for example, World Bank and United Nations Population Fund, *Female Genital Mutilation/Cutting in Somalia* (2004), pp. 22-25.

Sydney to organize a conference to review the extent of knowledge of the health consequences and treatment of FGM/C and to assess the efficacy of community-based interventions. Its second objective was to identify ways of strengthening leadership and improving the capacity for research on FGM/C in Africa by creating a network to explore the possibility of establishing an African coordination centre for the elimination of the practice.

The three-day meeting drew participants from Australia, Belgium, Ethiopia, Ghana, Indonesia, Kenya, Mali, Netherlands, Norway, Senegal, Sierra Leone, Somalia, Sudan, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America and Zambia.

### **B. Organization of the conference**

Held on 17-19 October 2011, at Nairobi's Southern Sun Mayfair Hotel, the conference consisted of nine sessions, including individual presentations and round-table discussions (see annex). Speakers addressed global challenges, the quality of research, efforts to eliminate the practice in Africa, obstetric and other complications, reconstructive surgery, medical and surgical treatment of long-term complications, FGM/C and HIV, work against the rite in Norway, relationships and negotiations of the issue among adolescent immigrant girls, the child's perspective on the ritual, legal and human rights aspects in Kenya, psychological consequences and treatment, sexual consequences, the role of cultural and social norms in perpetuating or abandoning the rite, determinants, harmful traditional practices, medicalization (see box 1), the training of health-care providers and programme implementers, community interventions and a design for evaluating interventions. In addition, a round-table discussion was held on the establishment of the African Coordination Centre for the Elimination of FGM/C.

#### **Box 1. Definition of "medicalization"**

"'Medicalization' of FGM refers to situations in which FGM is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of reinfibulation at any point in time in a woman's life."

Source: World Health Organization: UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, MWIA, WCPA, WMA, *Global strategy to stop health-care providers from performing female genital mutilation*. (Geneva, WHO, 2010), p. 2.

## *II. Summary and recommendations*



Participants unanimously agreed that FGM/C is a harmful practice, with austere physical, medical, psychological and social consequences, and that its eradication will depend on the collective efforts of all. They called for more research, with increased data collection and knowledge sharing about adverse effects of the practice. As remedial measures, the meeting proposed, along with increased research, mainstreaming FGM/C with other health issues such as antenatal care and HIV, and the establishment of a coordination centre to address the practice holistically. Strong beliefs in traditional cultural practices were identified as posing a major challenge to efforts to eliminate the practice. To overcome this, a dialogue on cultures was recommended as an integral component of initiatives to eradicate the practice.

Case studies from Ghana, Mali and the United States of America on corrective surgery for patients with infibulations revealed the extent of the damage caused by FGM/C. The studies also highlighted the need for documentation of the health consequences and the sharing of findings so that experts would have access to valuable data to build a strong case for treating FGM/C as a medical issue. The involvement of medical officers was seen as critical due to their influence among community members. To improve their capacity, it was recommended that the curriculum for training medical personnel include modules on how to document lessons learned in dealing with FGM/C cases.

Professor Isaac O. Kibwage, Principal, College of Health Sciences, UON, said that FGM/C remained a global problem despite the decline in prevalence indicated in national surveys. The solution would require the concerted efforts of all nations, he said. The proposed African Coordinating Centre for the Elimination of FGM/C would facilitate an exchange of information and expertise among countries and cultures.

Dr. Nesrin Varol of the University of Sydney saw in the conference the beginning of a long journey towards the

elimination of the practice. She said the vision of the proposed centre was to bring stakeholders together to achieve this goal.

Dr. Stephen Wanyee, Assistant Representative for UNFPA in Kenya, termed FGM/C a human rights issue because of its harmful effects on women's health, in particular on complications during childbirth. The medicalization of FGM/C was, he warned, an emerging threat to efforts to eradicate the practice. He said that UNFPA and UNICEF were working with Kenya's Ministry of Public Health and Sanitation to manage FGM/C cases and legal aspects, and he called upon the media to join the campaign.

Dr. Nafissatou J. Diop, Coordinator of the UNFPA-UNICEF Joint Programme on FGM/C, said the Joint Programme is intended to support the development of policies and programmes that will reinforce the efforts of national partners, development partners and civil-society organizations to accelerate the abandonment of FGM/C and to provide care to women and girls who have been subjected to the practice. In 15 African countries, the Joint Programme engages parliamentarians, media, traditional communicators, women lawyers, medical associations, religious leaders, scholars, women and youth to speak out against the practice. These countries are working together using a common approach to ending FGM/C.

The success behind the acceleration of eliminating FGM/C lies in the incorporation of a social-norms perspective:

- Ensuring an enabling national environment for the promotion of the abandonment of the practice
- Enabling communities to reaffirm the positive values shared within their culture
- Engaging all groups within a community in the discussion, including traditional and religious leaders, young girls themselves, women and men

- Ensuring discussion of the harms of the practice and that it is not a religious requirement, with information coming from trusted sources
- Facilitating public manifestations of the commitment to abandon the practice, thereby enabling people to see that others share the commitment
- Supporting the efforts of communities, including informing them of legislation and policies against the practice, which gives additional legitimacy to those committed to ending the practice.

Dr. Heli Bathija, from the World Health Organization/ Research and Training in Human Reproduction (WHO/HRP) in Geneva, called for a change of approach in tackling FGM, as the practice had changed from being a predominantly African to an international problem requiring a global solution. She said that ending the medicalization of FGM had been a priority of the organization since 1979.

Mr. Paul Dziatkowiec, the Deputy High Commissioner of Australia to Kenya, said his country's approach was based on the principle of gender equality and support for international development focused on women's rights and health, and the eradication of FGM/C. Progress on the health-related Millennium Development Goals (MDGs) is a priority, attracting about 17

per cent of Australia's development aid. In 2011-2012, some \$760 million would go towards strengthening the delivery of health services in developing countries and addressing the priority health needs of women and children. Mr. Dziatkowiec noted that Australia was a co-sponsor of resolutions for ending FGM/C at the United Nations Commission on the Status of Women and that it supported various international health organizations advocating legal and policy reforms, including WHO, UNFPA and UNICEF.

The UON Vice-Chancellor, Professor George Magoha, stressed the need for gender inclusiveness, saying: "There can be no sustainable development in any country if you remove women from the picture." FGM/C, he added, continued in Kisii, Meru and North Eastern Provinces of Kenya despite progress made towards its eradication.

The guest of honour at the conference, the Honourable Linah Jebii Kilimo, Assistant Minister for Cooperative Development and Chair of the Kenya Women Parliamentary Association, urged legislators and medical practitioners to collaborate and ensure the abandonment of FGM/C. She identified the need to address culture, especially the stigmatization of girls and women who reject FGM/C. Effectively tackling the problem would require a multiplicity of approaches, including strong legislation.



*Ms. Catherine Oneko, Australian Youth Ambassadors for Development—Centre for African Family Studies, with the Honourable Linah Jebii Kilimo, Chair of the Kenya Women Parliamentary Association and guest of honour at the conference.*

*The Kenya Women Parliamentary Association spearheaded the drafting of Kenya's Prohibition of Female Genital Mutilation Act 2010. The Act outlaws FGM for both girls and adult women and includes definitions of FGM in accordance with World Health Organization standards along with definitions of medical practitioner, midwife and law enforcer.*

### *III. Highlights of presentations and discussions*



## A. Legal and human rights perspectives

### 1. Legal and human rights aspects of FGM/C in Kenya

**Ms. Jane Serwanga, Federation of Women Lawyers (FIDA) — Kenya**

**Ms.** Jane Serwanga explained the legal and human rights aspects of FGM/C in Kenya, noting the presence of international and national legal instruments against the practice. They include the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Types of Discrimination against Women (CEDAW), and the Protocol to the African Charter on Human and People's Rights

(ACHPR), which allows individuals to sue States. In the absence of national legislation, international laws can be invoked.

In Kenya, some national efforts aimed at addressing female circumcision were made prior to the enactment of the FGM/C law. They include Sessional Paper No. 5 of 1995, the National Reproductive Health Policy of 2007 and the National Plan of Action for the Elimination of FGM/C and its inclusion in the Bill of Rights in the new Constitution. In the country's Social Pillar VISION 2030, the social pillars grant the right to physical integrity, to education, to health and to freedom from discrimination; they also recognize FGM/C as detrimental to human rights and development.

#### **Box 2. Prohibition of all forms of female genital mutilation, from the *Protocol to the African Charter on Human and Peoples' Rights (ACHPR) on the Rights of Women in Africa***

The Protocol includes the following provision:

"States parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women...[and] shall take all necessary legislative and other measures to eliminate such practices, including ... b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them..."

Source: Article 5, Elimination of Harmful Practices

## 2. Implications of the recent prohibition of female genital mutilation in Kenya

**Dr. Akunga Momanyi (UoN)**

**Dr.** Akunga Momanyi presented an overview of the structure and implications of Kenya's FGM/C Prohibition Act 2011. The law is divided into four sections covering definition, procedures for the establishment of an anti-FGM/C board, administrative procedures and offences. He listed the following, among the key elements: life imprisonment is the penalty for causing death through FGM/C; consent is not a defence; surgical procedures performed on medical grounds are excluded; abetting FGM/C is criminalized;

and taking people to another country for FGM/C is prohibited. The minimum penalty is three years' imprisonment or a fine of Ksh 200,000 or both. Using premises or possessing tools for performing FGM/C and/or failing to report cases are also criminalized, as is ridiculing or abusing a woman who rejects FGM/C.

To overcome these challenges, the sensitization of all stakeholders concerning the new law was emphasized, especially for medical professionals, the police, advocates and lawyers. Community involvement and participation will be required to promote empowerment and awareness of the need to protect the rights and dignity of women.

## B. International dimensions

### 1. Global challenges in the eradication of FGM

**Dr. Heli Bathija (WHO)**

**Dr.** Heli Bathija identified eight key challenges. They include the fact that FGM is a sensitive topic, dealing with sexuality, traditions, culture and religion. There is also the complexity of reported reasons for its continuation, which has polarized approaches for its elimination. Without hard data, Dr Bathija argued, it would be difficult to maintain advocacy for the elimination of the practice. Resources have been relatively scarce and dispersed. Coordination has been insufficient, although it has improved recently. Cooperation among United Nations organizations and agencies, non-governmental organizations (NGOs), government authorities and donor agencies has been weak but is also improving. There is often a lack of integration, linkages, mainstreaming with other issues and learning from solutions in other fields.

Dr. Bathija noted that FGM cannot be tackled in isolation because education and health are related.

It is, therefore, important to support a common, comprehensive rights-based approach. Working with champions such as community leaders, health-care workers, ministers and celebrities can make a difference. It would be important to develop initiatives at local, regional and international levels.

### 2. Need for state-of-the-art research on FGM

**Dr. Elise B. Johansen (WHO)**

**Dr.** Elise Johansen noted that research had not produced sufficient data on all aspects of FGM. There was no prevalence data on any health complication other than birth complications. Small-scale hospital-based studies give, however, some indications of health risks, e.g., haemorrhage between 8 per cent and 81 per cent in different studies, urinary problems in 58-68 per cent of women, infections in 8-37 per cent of women, labia fusion in 20 per cent, cysts in 12-43 per cent, keloid in 21-54 per cent, repeat FGM in up to 50 per cent of cases, and death in 2.3 per cent of cases. She noted the finding in a recent study from the

Gambia, covering 871 girls and women seeking help for gynaecological problems, that some 34 per cent of these problems were directly related to FGM.

### 3. Ten years of progress

**Ms. Sandra Jordan (USAID)**

**Ms.** Sandra Jordan discussed USAID involvement in efforts to eliminate FGM/C in Africa for more than 30 years. The programme began in the 1970s, and by the 1980s the agency had encouraged 24 missions to oppose the practice. In 1983, a partnership with the University of North Carolina resulted in the development of a handbook on FGM/C, *Health Effects of Female Circumcision*, which covered prevention, diagnosis and treatment of complications.

In the 1990s, the agency supported various initiatives, including the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995). In 1996, spe-

cific initiatives began with the USAID launch of a Gender Action Plan to ensure that gender was integrated into all agency policies and programmes. Other steps taken included: the development of a USAID Policy on FGM/C (2000); the establishment of the Development Working Group; the release of the 1st USAID Strategy on FGM/C (2001); and Mainstream FGM/C into Missions (2008). In 2010, USAID launched the Global Health Initiative.

Ms. Jordan noted the Demographic and Health Surveys (DHS) programme as one of the most significant contributions by USAID to the creation of an internationally comparable body of data on the demographic and health characteristics of populations in developing countries.

Challenges included a shift in priorities, a drop in the number of champions for the abandonment of FGM/C and reduced government funding to USAID for in-country activities.

## C. Ignorance and social and physical complications

### 1. Harmful traditional practices in Ethiopia

**Dr. Yayehiyad Kitaw (Journal on Female Genital Mutilation and Other Harmful Traditional Practices)**

**Dr.** Yayehiyad Kitaw discussed the harmful traditional practices he encountered in his work. He listed 15 major traditional practices, with FGM/C considered to be the most harmful. More than 160 traditional practices are considered harmful.

FGM/C was prevalent where people were ignorant about the morphology of female sexual organs. He underlined the importance of life-skills training in the successful empowerment of the girl child. Reaching

boys was also deemed necessary as their preference plays a significant role in the marriageability of the girls. If the demand to marry only circumcised women ceased, there would presumably be less support for FGM/C.

### 2. Complications associated with FGM/C

**Dr. Peter Baffoe (Ghana Health Service)**

**Dr.** Peter Baffoe spoke about his experience and lessons learned from treating patients in Ghana. He noted that victims continued to suffer long after the cut. Besides physical trauma, victims also experienced medical (short- and long-term) complica-

tions and psychological trauma. Primary complications were related to pain, haemorrhage, shock and injuries to the adjacent organs. Urinary retention as well as fractures and dislocations resulting from trauma incurred due to forceful restriction of the victim were also observed. Symptoms reflective of psychological trauma include hatred, bitterness, and feelings of betrayal, loss of self-esteem, anxiety, loss of trust, feelings of incompleteness and fear.

In the long term, various difficulties such as urinary incontinence, urinary tract infections, infertility, fistulae and HIV transmission were recorded. Sexual complications, lack of sexual satisfaction and birth complications were also identified as long-term effects.

### **3. Treatment of complications: experience from the field**

**Dr. Moustapha Touré (Université de Bamako)**

**Dr.** Touré spoke about his experience in treating FGM/C complications in Mali, where the practice is widespread, with crude instruments being used on thousands of girls, including newborns, in towns and villages. As a result, many women experience physical and emotional difficulties. Cases presented to his clinic included dystocia, tightened/narrow vaginal orifices, cysts, keloids, abscesses and vaginal bridles.

Many women reported difficulties in coitus, resulting in social problems such as divorce and frustration over failure to consummate marriage. The majority suffer in silence, lacking an opportunity to seek corrective medical intervention.

### **4. Obstetrics complications associated with FGM—WHO Obstetrics Sequelae Study**

**Professor Joseph Karanja (UoN)**

**P**rofessor Joseph Karanja reported on the WHO Obstetrics Sequelae Study, the largest ever conducted on FGM. It involved 28,000 participants selected by

FGM type and country (see box 3 for classification of types of FGM). Participants were from six countries: Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan.

The study found that obstetric complications were higher among women who had undergone FGM and became increasingly severe with the severity of the cut. The study evaluated the relationship between different types of FGM and obstetric complications and estimated the incidence of obstetric complications among women with FGM giving birth in hospitals.

Women with FGM Type II and III (see Box 3) had a higher propensity for having a Caesarean section, being hospitalized for more than three days and having episiotomy and perineal tears than those who had not. Similarly, the relative risk of having an infant requiring resuscitation and a stillbirth at delivery was significantly elevated in women with Type II and III. In this study, the lack of effect on birthweight despite the clear adverse effect on the delivery process supports a hypothesis of a mechanical problem (lack of elasticity of cut/excised tissues).

### **5. Surgical outcomes and clients' satisfaction with reconstructive surgery for female genital mutilation: a critical initiative against FGM/C**

**Dr. Atif Fazari (University of Medical Sciences and Technology, Khartoum, Sudan)**

**Dr.** Atif Fazari discussed the findings of a study conducted in Khartoum from January 2005 to June 2010, involving 660 women who had undergone reconstructive surgery. The study confirmed that reconstructive surgery could restore some of the genital anatomy to a high degree of satisfaction. Some 86 per cent were very satisfied with the procedure; 80 per cent were happy with the appearance of the vulva; 80 per cent, with the disappearance of vaginal discharge; and 98 per cent, with the regaining of sexual activity. The study recommended the enactment of laws to

### Box 3. Types of female genital mutilation

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV. All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

Source: World Health Organization, *Eliminating female genital mutilation: An interagency statement* (Geneva, 2008), p. 4. The text notes that "Experience with using this classification over the past decade has brought to light some ambiguities. The present classification... incorporates modifications to accommodate concerns and shortcomings....", p. 4.

break the cultural silence and offer more reconstructive surgery.

### 6. Medical-surgical treatment of long-term complications

**Dr. Nawal Nour (African Women's Health Center - Brigham and Women's Hospital, Boston, Mass., USA)**

According to Dr. Nawal Nour, most cases involving long-term complications require delicate and complicated surgery. They include keloids, de-infibulations, obstetric challenges, yeast infections and urinary tract infections. She said many of the cases required holistic interventions involving surgical-medical and psychosocial procedures.

The African Women's Health Center at Brigham and Women's Hospital, an affiliate of Harvard University, was established to provide reproductive health services to immigrants, especially those from North Africa. The centre has a committed team of surgeons and community workers. Dr. Nour aims at ensuring that her clients and patients change their mindsets from victims to survivors.

### 7. Female genital cutting and HIV in Sub-Saharan Africa: preliminary findings from Demographic and Health Surveys

**Dr. Ian Askew (Population Council)**

Dr. Ian Askew presented the preliminary findings of research on the connection between FGM/C and HIV in sub-Saharan Africa. The study was based on data from Demographic and Health Surveys in seven sub-Saharan African countries: Burkina Faso, Cameroon, Ethiopia, Guinea, Kenya, Liberia and Mali.

Potentially, FGM/C can fuel the spread of HIV in several ways, including through contaminated tools, tearing during sex and preference for anal sex, among others. However, Dr. Askew said that any association between FGM/C and the prevalence of HIV might be due to other factors, pointing out that the results needed further analysis to incorporate additional factors.

## D. Challenges for immigrants

### 1. Work against FGM/C in Norway

**Dr. Geir Borgen (Norwegian Centre for Violence and Traumatic Stress Studies)**

**Dr.** Geir Borgen estimated the number of FGM/C cases in Norway at 10,000, two thirds of which were Type III (see box 3). He said the majority were immigrants of Somali origin. About 5,000 young girls were at potential risk, with the actual risk unclear and a source of debate. Some 70-80 per cent of the families still practise FGM/C, although for others it had lost much of its cultural and social meaning. For those families it was no longer a norm and was likely to be carried out only to a small extent.

The practice is illegal in Norway and considered a violation of human rights. The law punishes accomplices and does not recognize consent as a defence. Health professionals and child-care workers are obligated to report any cases.

The Norwegian Government has taken other steps to combat FGM/C, including a project to provide arguments and strategies that would aid people in resisting social pressures to subject their children to the rite. Provisions were made for victims to access health care countrywide. In addition, a guide for health professionals on how to treat FGM/C was developed, and a refugee education programme on Norwegian laws concerning forced marriage and FGM/C was initiated.

Norway supports initiatives and programmes internationally, in Egypt, Eritrea, Ethiopia, Kenya, Mali, Somalia, Sudan, and the United Republic of Tanzania. Norway also backs the UNFPA-UNICEF Joint Programme on FGM/C.

### 2. Relationships and negotiations concerning FGM/C among adolescent girls in the Norwegian context

**Dr. Mona-Iren Hauge (Norwegian Centre for Violence and Traumatic Stress Studies)**

**Dr.** Mona-Iren Hauge carried out a study to find out how girls who had undergone FGM/C fitted within the Norwegian school context. The study found that FGM/C generated a shared sense of shame in the community as a whole and identified the need for care and protection of girls who had undergone the rite. The girls rarely discussed it with others, especially those who had not undergone it.

Immigration placed a demand on targeted girls to find new ways of perceiving themselves. There was a need to denounce the practice without condemning targeted girls or their families. It also demanded a new understanding of circumcision, that it was not a taboo in itself but a practice rooted in culture.



## E. Social consequences

### 1. The ritual of female genital mutilation understood from a child's perspective

**Dr. Jon Håkon Schultz (Norwegian Centre for Violence and Traumatic Stress Studies)**

**Dr.** Jon Håkon Schultz reported on the results of a study that explored strategies employed in preparing girls for circumcision and how those strategies affected their understanding of the ritual and the establishment of a new identity.

The study found that an “open” strategy initially elicited a feeling of longing for the cut whereas the “closed” strategy evoked fear and suspicion. Nevertheless, both strategies had the same negative effect on the victims. The ritual was never fully explained, and the girls did not get an opportunity to deal with the event emotionally. In exile, however, those girls exposed to the possibility of not undergoing circumcision began to question the practice.

### 2. Hitting the bottom

**Dr. Inger-Lise Lien (Norwegian Centre for Violence and Traumatic Stress Studies)**

**Dr.** Inger-Lise Lien discussed the process of internalization and how it could be used to inform the design of strategies to foster changing attitudes and behaviour.

Dr. Lien identified four levels of change. At the topmost level, people accept suggestions to change only at a superficial level. At the second level (cliché), people pay lip service to an ideal that they do not believe in or practise, such as publicly condemning FGM/C while privately subscribing to it. At the third level (internalization), a few people understand the logic in the suggestion to change and begin practising it. At the deepest level (motivation), people are moved to act on their convictions; for example, traditional practitioners may become active anti-FGM/C campaigners. The challenge is to identify the perspective to promote in order to tip the numbers to one's advantage.

## F. Sexual consequences

### 1. Sexual consequences: a systematic review

**Dr. Rigmor C. Berg (Norwegian Knowledge Centre for the Health Service)**

**Dr.** Rigmor C. Berg described a 2008 study to investigate the health and sexual consequences of FGM/C. Study participants were some 12,761 women from seven countries: the Central African Republic, Egypt, Gambia, Ghana, Nigeria, Saudi Arabia and Sudan.

The results showed that women who had undergone the rite had a higher likelihood (1.5-2 times) of experiencing sexual complications. Those who had undergone FGM/C were 1.5 times more likely to experience pain during intercourse. Other complications included low sexual satisfaction, a drop in sexual desire and limited initiation of sex. Also, women who had undergone FGM/C had a higher likelihood of failing to achieve orgasm.

The study concluded that the rite could be associated with the reduction of a woman's sexual functioning. Some of these effects are physiological, as FGM/C can damage vascular tissues, affecting the natural sexual response.

## 2. Veiled pain: psychological, social and relational consequences of FGM/C in the Netherlands

**Ms. Anke van der Kwaak (Royal Tropical Institute)**

**Ms.** Anke van der Kwaak presented research findings on problems of women who had undergone FGM/C. The study, which involved a total of 66 immigrant women from five African countries, sought to identify whether FGM/C led to psychological, social and relational problems and their nature. Second, it examined factors that contributed to these problems and identified coping styles the women had developed.

The findings revealed psychological, emotional and social difficulties among women who had undergone the cut. The women reported having bad memories whenever they encountered pain. Others felt isolation and exclusion, anger, pain and silence. Many suffered relational and psychological consequences manifested in their sexual experiences and fear of pain. The women were strongly affected by their first coitus, media attention and/or visits to their country of origin.

Coping styles varied. Some patients chose to accept to live with their new realities; others turned to religion; and others felt disempowered and traumatized. These coping styles were exhibited in activities such as reading the Quran, isolation and the consumption of alcohol and drugs.

## G. Cultural factors

### 1. The role of social norms and conventions in the perpetuation and abandonment of FGM/C

**Dr. Bettina Shell-Duncan (University of Washington)**

**Dr.** Bettina Shell-Duncan conducted a study on the role of social norms and conventions in the perpetuation and abandonment of FGM/C in the Gambia. The study examined the dynamics of change based on leading behavioural theories of change. The predications of the Social Convention Theory hold that FGM/C should be necessary for marriage or as an avenue to better marriage prospects; be self-enforcing, with the expectation that other girls will be cut as the primary reason for complying; with the cutting practice more valued and conserved than the accompany-

ing training or ritual; and the cutting practice be prone to exaggeration, as girls compete for better husbands.

The Gambian study, based on in-depth interviews as well as focus groups, found that FGM/C was insignificant in marriage except in polygamous settings, in which an uncircumcised wife was likely to face ridicule from her co-wife/wives. Other reasons — including social pressure, religious responsibility, fertility, proper parenting and the attenuation of sexual desire — were given instead of marriage.

The study concluded that FGM/C is driven by strong peer conventions and intergenerational influences. The implications for policy include the need for greater coordination among interventions, which should be locally attuned and address potentially shifting contexts.

## 2. Determinants of FGM/C: How strong they are in the continuation of FGM/C among women in Ethiopia

**Professor Morankar Sudhakar (Jimma University, Jimma, Ethiopia)**

Professor Morankar Sudhakar discussed a study that sought to understand the sociocultural determinants that play a role in perpetuating FGM/C in Ethiopia, where FGM/C prevalence was found to be 80 per cent, and culture was the greatest determinant, at 99 per cent.

In Ethiopia, FGM/C is performed on girls between the ages of 1 and 15. The main reasons for the practice are adherence to core cultural values of sexuality and religious and ethnic-group requirements. The girl child is never consulted. Gender, religion, ethnicity, income, education and several group differences played an important role in accessing health-care services as well as in conforming to harmful practices. Parents who believe the practice is harmful make decisions simply to abide by social and cultural norms.

## H. Other challenges

### 1. Prevention of the medicalization of FGM

**Dr. Elise B. Johansen (WHO)**

Dr. Elise Johansen addressed what could be regarded as the “boomerang effect” of increased information and knowledge concerning the health risks posed by FGM performed, predominantly, outside medical facilities. The long-standing assumption that increased access to information on the negative effects of FGM would discourage the practice has not been realized as hoped for. On the contrary, people have turned to health-care providers in the hope of mitigating the immediate health risks, and different health-care providers are increasingly performing FGM.

A study showed that medicalization was prevalent in Egypt, Guinea, Kenya, Nigeria, Sudan and Yemen. Prevalence was highest in Egypt, at 75 per cent, and lowest in Yemen, at 8 per cent. In Kenya, prevalence was among daughters, indicating that medicalization is a recent phenomenon. In the other countries, it was among mothers, indicating that it has long been practised.

Medicalization presents a great danger to efforts to reduce FGM. Because it legitimizes, institutionalizes and helps spread the practice, it risks cultivating the professional and financial interest of medical practitioners. The encouragement of male circumcision for health purposes was seen as likely to cause confusion between the two — hence the need for special attention.

The global strategy to address the medicalization of FGM includes creating a legal framework, strengthening the health system’s capacity, mobilizing political and financial support and strengthening monitoring, evaluation and accountability.

### 2. FGM/C in health training

**Dr. Guyo Jaldesa (UON)**

Dr. Guyo Jaldesa said training in Kenya was focused on improving the capacity of the health system to deal with FGM/C cases. This entails the development of a curriculum to improve the management of pregnancy, delivery and post-partum care for women who have undergone FGM/C. These materials can be used for pre- and in-service training by health

workers providing antenatal and basic obstetric care. The management of gynaecological and sexual complications is a key objective of the training.

Dr. Jaldesa emphasized the need for a two-pronged approach to educating health workers against the prac-

tice. To make the topic acceptable in a conservative society, efforts should be made to blend FGM/C into easily acceptable topics such as safe motherhood.

## I. Community-based interventions

### 1. How community-based interventions work

**Dr. Nafissatou J. Diop (UNFPA)**

**Dr.** Nafissatou J. Diop noted that community interventions work best when community members are involved and consulted. "If the messenger is the message and the messenger is as important as the message, to communicate to groups of people it is prudent to first identify influential people in society and then use their networks in the snowball fashion," she said.

The planning stage for behaviour-change programmes is critical and needs to be premised on theories of change to ensure coverage and inclusion of all the important elements of the initiative. These include the magnitude of the desired change, intensity of the programme (time available), coverage and mapping and outcome.

### 2. What works and what doesn't work

**Dr. Els Leye (International Centre for Reproductive Health)**

**B**ased on 15 years of experience, Dr. Els Leye mapped trends to determine what works and what does not. Dr. Leye noted that many countries have recorded declines in prevalence. However, the "Knowledge Attitudes and Practices" gap continues to widen as discrepancies persist between what people know and what

they practise. There is evidence of a notable move from infibulations to the Sunnah-type FGM/C. Concerns about health risks have led to an increase in medicalization as more people opt for the so-called safer procedure. Gaps in legislation have weakened the legal approach, especially in Europe, where re-infibulations have continued to be performed because the law is silent on them. Changes in the ritual have been observed. Also, the practice has become more secretive because of the possibility of prosecution.

To ensure large-scale abandonment, programmes must be based on knowledge of the rite as a social convention and must apply interventions that ensure community empowerment, with a focus on human rights adapted to local conditions.

### 3. Similarities and differences in the usefulness of community interventions: roundtable discussion

**P**rofessor Isaac Nyamongo, UON, pointed out that the demand for FGM/C was mainly from the family, with the societal level (practitioners) and the health-facility level (medical staff) as providers of the service. However, although decisions to obtain it were made by the family, those decisions were based on community beliefs and practices, financial considerations and the desire to conform.

Different interventions must be applied with multi-faceted approaches. Community-level initiatives may include legislation, Alternative Rites of Passage (ARP) ceremonies, education, alternative training of circumcisers and the involvement of local and religious leaders in empowerment programmes. Professor Nyamongo said the challenge was how to determine the best level at which to put resources to get maximum returns.

In Kenya, ARP is a popular response to FGM/C. However, it requires intensive preparation, including certain aspects of the traditional version, for example: maintaining age sets, conducting it in the usual FGM/C season and engaging traditional practitioners to make it acceptable to the community. The challenges include insufficient involvement of parents, cultural atrophy, insufficient funding, shortage of credible advocates and the lack of safety nets to support the girls who may have to deal with peer pressure.

Ms. Charity Koronya (UNICEF Somalia) said the abandonment of FGM/C was heavily reliant on getting the right messenger to spread the message. In certain communities — for example, among the Pokot, Njemps and Kuria in Kenya — old people are the custodians of culture and have high respect for government. This can be harnessed as a means to advocate the ban of FGM/C at functions attended by government officials. The danger is the risk that the rite will go underground.

Community dialogue is crucial in fighting FGM/C. However, to achieve the best results certain key aspects need to be considered, beginning with what community members know, building on previous relationships and the capacity of facilitators, demystifying cultural misconceptions (e.g., concerning female anatomy) and addressing other needs. However, more research is necessary, as knowledge gaps persist.

#### 4. Design Considerations for the Evaluation of FGM/C Initiatives

**Dr. Ian Askew (Population Council)**

**Dr.** Askew described evaluation as a critical and vital process that provides evidence on the viability of programmes, and their success or failure to achieve a set of objectives. It assesses the type of change against the proposed objectives and the effects or impact of the activities on behaviour change.

When designing an FGM/C evaluation an important requirement is that it should be based on the theories of change. Along with this three considerations should be made as follows:

- Determining why the practice persists
- The readiness of the community to change
- Whether change has already started

Impacts and effects should be measurable and whether expected or unexpected, positive or negative, be diligently recorded. The challenge to evaluating FGM/C status include the use of self-reports and indirect observation, and the ambiguous measures for indicators of knowledge, attitude and intentions of behaviours and denial. Contamination by unplanned influences which may enhance or hamper the results is a long standing challenge. The practice of programme evaluation must be guided by ethical considerations like beneficence, non-maleficence and honesty.

## J. Establishment of the African Coordinating Centre for the Elimination of FGM/C

**Dr.** Nesrin Varol, University of Sydney, introduced the topic of establishing the African Coordinating Centre for the Elimination of FGM/C, envisioned as a 15-year project in collaboration with WHO, UNFPA, UNICEF, UON, ICRH (Ghent University), the University of Washington (USA), the University of Sydney, the Africa-Australia Universities Network and the World-wide Universities Network (WUN).

She said the intention was to create a centre of excellence aimed at accelerating actions for the elimination of FGM/C. It would offer capacity-building for those who lead prevention programmes and create synergies among various approaches in the campaign. Networking would involve national governments, NGOs, the media, university and research institutions, communities, and corporate bodies. Lastly, Dr. Varol noted that community-driven interventions would be an aspect of the proposed centre's framework.

Professor Charles Omwandho, Dean, School of Medicine, UON, noted that the conference had addressed the significant influence of FGM/C on the health of women, physically and mentally, depriving them of basic human rights. He said the way forward would include further

research on FGM/C, particularly in regard to evidence-based health care and preventative approaches. He also spoke about the need for the development and dissemination of training curricula and guidelines, for further monitoring and evaluation and for the establishment of the African Coordinating Centre for the Elimination of FGM/C, to be hosted by UON.

On the proposed African Coordination Centre for the Elimination of FGM/C, UON Professor Joseph G. Karanja noted that much capacity-building would be required to make the centre a reality. Professor Karanja said the vision was to create a centre of excellence for African researchers to develop innovative approaches to deepen an understanding of FGM/C. The centre would train leaders and champions to promote actions towards the abandonment of FGM/C in Africa and beyond through innovative research, leadership training and networking.

The mobilization of human and material resources at the global level would enable further research on FGM/C, develop better understanding of the consequences of FGM/C and promote the design of ways to eliminate the rite wherever it is prevalent.



## IV. List of participants

Abdikadir, Maryani	Child Protection Specialist	United Nations Children's Fund	Nairobi, Kenya
Abrar, Leila	Consultant	Communication for Development United Nations Children's Fund Somalia	Nairobi, Kenya
Ahmed, Zainab	Child Protection Specialist	United Nations Children's Fund	Nairobi, Kenya
Aroka, Elizabeth	Legal Officer	International Centre for Reproductive Health	Mombasa, Kenya
Askew, Ian, Dr.	Director	Reproductive Health Services and Research Population Council	Nairobi, Kenya
Avni, Michal	Senior Gender Adviser	United States Agency for International Development	Washington DC, USA
Baffoe, Peter, M.D.	Senior Specialist,	Obstetrics/Gynaecology Ghana Health Service Bolgatanga Regional Hospital	Ghana
Bathija, Heli, Dr.	Area Manager	World Health Organization	Geneva, Switzerland
Berg, Rigmor "Rimo", Dr.	Researcher	Norwegian Knowledge Centre for the Health Service	Oslo, Norway
Bjälkander, Owolabi	Researcher (Ph.D.)	Karolinska Institutet	Freetown, Sierra Leone
Borgen, Geir, Dr.	Researcher	Norwegian Centre for Violence and Traumatic Stress Studies	Oslo, Norway
Burje, Sarah	Council Officer	Nursing Council of Kenya	Nairobi, Kenya
Chapeta, Lister	Programme Officer	United Nations Population Fund	Nairobi, Kenya
Chege, Jane, Dr.	Director	Research, Design, Monitoring and Evaluation for Global Health World Vision International	Lusaka, Zambia
Cumming, Robert, Prof.		School of Public Health University of Sydney	Sydney, Australia
Daly, Anthony	Africa Regional Maternal Health Adviser	Department for International Development British High Commission	Nairobi, Kenya
Diop, Nafissatou J., Dr.	Coordinator	UNFPA-UNICEF Joint Programme on FGM/C United Nations Population Fund	New York, NY, USA
Dziatkowiec, Paul	Deputy High Commissioner	Australian High Commission	Nairobi, Kenya
Fazari, Atif Bashir E., Dr.	Associate Professor	Department of Obstetrics and Gynaecology University of Medical Sciences and Technology	Khartoum, Sudan
Gachanja, Florence	National Programme Officer	United Nations Population Fund	Nairobi, Kenya
Gichohi, Muthoni	Health Information and Documentation Specialist	Family Health Options Kenya	Nairobi, Kenya
Gitonga, Maureen	Programme Advisor	Kenya Women Parliamentary Association Kenya National Assembly	Nairobi, Kenya
Handulle, Fatima F.	Project Officer	United Nations Children's Fund Somalia Support Centre	Nairobi, Kenya
Hassan, Samia, Dr.		United Nations Population Fund, Somalia	Nairobi, Kenya
Hauge, Mona-Iren, Dr.	Researcher	Norwegian Centre for Violence and Traumatic Stress Studies	Oslo, Norway
Ismail, Martha Santoso	Assistant Representative	United Nations Population Fund	Jakarta, Indonesia
Jaldesa, Guyo W., Dr.	Department of Obstetrics and Gynaecology	University of Nairobi	Nairobi, Kenya
Jebii Kilimo, Hon. Linah M.P., Marakwet East	Chairperson	Kenya Women Parliamentary Association	Nairobi, Kenya
Johansen, Elise B., Dr.	Technical Officer	World Health Organization	Geneva, Switzerland
Jordan, Sandra	Senior Technical Adviser	United States Agency for International Development	Washington, DC, USA
Kabaru, Mary	Chief Gender Officer	Ministry of Gender	Nairobi, Kenya
Karanja, Joseph G., Prof.	Department of Obstetrics and Gynaecology	University of Nairobi	Nairobi, Kenya

Karanja, Nancy	Program Assistant	United Nations Population Fund	Nairobi, Kenya
Kibwage, Isaac O., Prof.	Principal, College of Health Sciences	University of Nairobi	Nairobi, Kenya
Kigundu, Christine, Prof.	Department of Human Pathology	University of Nairobi	Nairobi, Kenya
Kimani, Margaret	Office Coordinator	Kenya Media Network on Population and Development	Nairobi, Kenya
Kimani, Violet N., Prof.	Department of Community Health	University of Nairobi	Nairobi, Kenya
Kirumbi, Leah, Dr.	Researcher	Reproductive Health Research Unit The Kenya Medical Research Institute	Nairobi, Kenya
Kitaw, Yayehyirad Yitateku, Dr.	Editor-in-Chief, Journal on Female Genital Mutilation and Other Harmful Traditional Practices	Public Health Physician	Addis Ababa, Ethiopia
Koronya, Charity	Programme Specialist FGM/C	United Nations Children's Fund Somalia Support Centre	Nairobi, Kenya
Lalla-Maharajh, Julia	Chief Executive Officer and Founder	Orchid Project	London, United Kingdom
Lavussa, Joyce, Dr.	NPO/FHP	World Health Organization	Nairobi, Kenya
Leye, Els, Dr.	Senior Researcher	International Centre for Reproductive Health	Ghent, Belgium
Lien, Dr. Inger-Lise	Researcher	Norwegian Centre for Violence and Traumatic Stress Studies	Oslo, Norway
Ludeke, Melissa	Australian Youth Ambassador for Development	University of Nairobi	Nairobi, Kenya
Maagu, Beatrice K.	Assistant Consultant		Nairobi, Kenya
Magoha, George, Prof.	Vice Chancellor	University of Nairobi	Nairobi, Kenya
Mbatia, Paul Nyaga	Associate Professor	Department of Sociology University of Nairobi	Nairobi, Kenya
McConville, Fran	Health Advisor	Department for International Development British High Commission	Nairobi, Kenya
Mohamed, Fatima Nimo	Chairperson	Horn of Africa Community Based Health Project	Nairobi, Kenya
Momanyi, Akunga, Dr.	Lecturer	School of Law University of Nairobi	Nairobi, Kenya
Moschini, Stefano	Intervita		Nairobi, Kenya
Mucheru, Muthoni	Legal Intern		Karatina, Kenya
Muchira, Muraguri	Acting Executive Director	Family Health Options Kenya	Nairobi, Kenya
Muhumed, Fatuma	Humanitarian Response Associate	United Nations Population Fund, Somalia	Nairobi, Kenya
Murgor, Caroline	Programme Officer	Maendeleo Ya Wanawake	Nairobi, Kenya
Muthuri, Eva	Project Team Leader	African Family Health	Nairobi, Kenya
Mutungi, Alice K., Prof.	Department of Obstetrics and Gynaecology	University of Nairobi	Nairobi, Kenya
Ndambuki, Rose	Research Nurse Counselor	Kenya Aids Vaccine Initiative	Nairobi, Kenya
Noordin, Rukiya, Imam	Gender Based Violence National Technical Advisor	Supreme Council of Kenya Muslims/German International Cooperation (SUPKEM/GIZ)	Nairobi, Kenya
Nour, Nawal, Dr.	Director	African Women's Health Center Brigham and Women's Hospital	Boston, Mass., USA
Nungari Salim, Neema, Dr.	Lecturer	Department of Sociology University of Nairobi	Nairobi, Kenya
Nyamongo, Isaac K., Prof.		University of Nairobi	Nairobi, Kenya
Nyirenda-Meme, Margaret, Dr.	Senior Assistant Director	Medical Services Ministry of Public Health and Sanitation	Nairobi, Kenya
Ochieng, Christine	National Coordinator	UNFPA-UNICEF Joint Programme on FGM/C Ministry of Gender	Nairobi, Kenya
Ocholi, Martin W.	Consultant	United Nations Population Fund	Nairobi, Kenya

Odula-Obonyo, Carol, Dr.		Kenya Medical Women's Association	Nairobi, Kenya
Olungah, Owuor, Dr.	Gender and African Studies	Institute of Anthropology University of Nairobi	Nairobi, Kenya
Omwandho, Charles, Prof.	Dean	School of Medicine University of Nairobi	Nairobi, Kenya
Oneko, Catherine	AYAD Welfare Support Officer	Australian Youth Ambassadors for Development—Centre for African Family Studies (AYAD - CAFS)	Nairobi, Kenya
Ongore, Dismas, Dr.	Director	School of Public Health University of Nairobi	Nairobi, Kenya
Opira, Jacque	Administrative Assistant	Department of Obstetrics and Gynaecology University of Nairobi	Nairobi, Kenya
Ouedraogo, Idrissa	Technical Advisor	United Nations Population Fund	Dakar, Senegal
Parmuat, Lanoi	Programme Director	Free Pentecostal Fellowship in Kenya	Nairobi, Kenya
Patel, Anjana	Personal Assistant	United Nations Population Fund	Nairobi, Kenya
Piccone, Antonia	Intern/Student	Kakenya's Dream	Kilgoris, Kenya
Qazi, Zaitoon, Dr.	National Officer	United Nations Children's Fund Somalia Support Centre	Nairobi, Kenya
Qureshi, Zahida, Dr.	Senior Lecturer	Department of Obstetrics and Gynaecology University of Nairobi	Nairobi, Kenya
Ronning, Sidsel	Integration Advisor	Norwegian Embassy	Nairobi, Kenya
Schultz, Jon-Håkon	Researcher	Norwegian Centre for Violence and Traumatic Stress Studies	Oslo, Norway
Serwanga, Jane	Deputy Executive Director	Federation of Women Lawyers - Kenya (FIDA Kenya)	Nairobi, Kenya
Shell-Duncan, Bettina, Dr.	Professor of Anthropology	University of Washington	Seattle, Washington, USA
Shurie, Zahara Ali	Chairperson	Maendeleo Ya Wanawake	Garissa, Kenya
Sudhakar Narayan, Morankar, Dr.	Professor	Jimma University	Jimma, Ethiopia
Suleiman, Sawsan Eltahir	Director	National Reproductive Health Programme Federal Ministry of Health	Khartoum, Sudan
Thompson, David	Graduate Attaché	British Institute in Eastern Africa	Nairobi, Kenya
Touré, Moustapha, Dr.	Maître Assistant	Chef du Service de Gynecologie Obstetrique Université de Bamako Hopital du Mali	Bamako, Mali
Tureti, Martha	Coordinator	National Gender and Development World Vision Kenya	Nairobi, Kenya
Van der Heuvel, Daisy	Midwife/Nurse	Klina Hospital	Belgium
van der Kwaak, Anke	Senior Advisor	Royal Tropical Institute	Mauritskade, Amsterdam Netherlands
Van Rumst, Dorothea	Midwife		Ghent, Belgium
Varol, Nesrin, Dr.	Gynaecologist and Senior Lecturer	University of Sydney	Sydney, Australia
Wakahe, Jane K., Dr.	Gynaecologist	Private/School of Public Health	Nairobi, Kenya
Wakasiaka, Sabina, Dr.	Lecturer	School of Nursing University of Nairobi	Nairobi, Kenya
Wanyee, Stephen, Dr.	Assistant Representative	United Nations Population Fund	Nairobi, Kenya
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Yassin, Rukia	Programme Officer	Gender Based Violence German International Cooperation (GIZ)	Nairobi, Kenya
Younis, Safia Jibril	Child Protection for Social Change	United Nations Children's Fund Somalia Support Centre	Nairobi, Kenya

# Annex I

## Conference Programme

### DAY ONE

#### 9.00-10.30am **OPENING CEREMONY**

Chairperson:

Professor  
Charles O.A. Omwandho  
Dean, School of Medicine  
University of Nairobi

**Drama by Catholic Diocese of Nakuru**

#### **Welcoming Addresses:**

##### **Mr Paul Dziatkowicz**

Deputy High Commissioner  
Australian High Commission

##### **Professor Isaac O. Kibwage**

Principal, College of Health Sciences  
University of Nairobi

##### **Dr. Nesrin Varol**

Gynaecologist and Senior Lecturer  
University of Sydney

##### **Professor George Magoha**

Vice Chancellor  
University of Nairobi

##### **Dr. Heli Bathija**

Area Manager  
World Health Organization

##### **Dr. Nafissatou J. Diop**

Coordinator  
UNFPA-UNICEF Joint Programme on FGM/C  
United Nations Populations Fund

#### **Guest of Honour:**

##### **The Honourable Linah Jebii Kilimo**

Assistant Minister for Cooperative Development  
Chair, Kenya Women Parliamentary Association

11.00am-  
12.00pm

#### **SESSION ONE: ROUNDTABLE DISCUSSION WITH MINISTRY REPRESENTATIVES**

12.00-1.00pm **SESSION TWO: KEYNOTE ADDRESSES**

Chairperson: Dr. Ian Askew

Global challenges in the elimination of FGM/C

Dr. Heli Bathija

State of health and research and FGM/C

Dr. Elise B. Johansen

FGM/C abandonment efforts in Africa: Ten years of progress

Sandra Jordan

2.00-3.00pm **SESSION THREE: ADDRESSING IMMEDIATE AND LONG-TERM COMPLICATIONS**

Chairperson: Professor Robert Cumming

Drama by Catholic Diocese of Nakuru

UNFPA (Kenya Country Office)  
Video Presentation: Seven Billion Actions

#### **Presentations:**

Complications associated with FGM/C

Dr. Peter Baffoe

Obstetrics complications associated with FGM/C: WHO obstetrics sequelae study

Professor Joseph Karanja

Treatment of complications: experience from the field

Dr. MOUSTAPHA Touré

3.30-5.00pm **SESSION THREE (continued)**

Chairperson: Dr. Bettina Shell-Duncan

**Presentations:**

Surgical outcomes and the clients' satisfaction with reconstructive surgery for female genital mutilation: a critical initiative against FGM/C

*Dr. Atif Fazari*

The treatment of long-term gynaecological complications: knowledge and knowledge gaps

*Dr. Nawal Nour*

Female genital cutting and HIV: Evidence from the Demographic and Health Surveys in sub-Saharan Africa

*Dr. Ian Askew*

**4.30-5.30pm SESSION FOUR: NORWEGIAN CENTRE FOR VIOLENCE AND TRAUMATIC STRESS STUDIES WORKSHOP**

*Chairperson: Professor Violet Kimani*

The work against FGM/C in Norway

*Dr. Geir Borgen*

Voicing the unspeakable: Addressing FGM/C in Norwegian school contexts

*Dr. Mona-Iren Hauge*

The ritual of FGM/C understood in a child perspective

*Dr. Jon-Håkon Schultz*

Hitting the bottom

*Dr. Inger-Lise Lien*

**DAY TWO**

**8.30-8.40am RE-CAP OF PREVIOUS DAY**

**8.40-9.30am SESSION FIVE: LEGAL AND HUMAN RIGHTS**

*Chairperson: Dr. Els Leye*

Legal and human rights aspects of FGM/C in Kenya

*Jane Serwanga*

**Discussion**

**9.30-10.30am SESSION SIX: PSYCHOLOGICAL AND SEXUAL CONSEQUENCES**

*Chairperson: Dr. Nesrin Varol*

**Presentations:**

Sexual consequences, a systematic review

*Dr. Berg Rigmor*

**11.00am-1.00pm SESSION SEVEN: THE ROLE OF CULTURE AND SOCIAL NORMS**

*Chairperson: Dr. Nafissatou J. Diop*

**Keynote Address:**

The role of social norms and conventions in the perpetuation and abandonment of FGM/C

*Dr. Bettina Shell-Duncan*

**Presentations:**

Determinants of FGM/C: How strong they are in continuation of FGM/C among women in Ethiopia

*Professor Morankar Sudhakar*

Harmful traditional practices in Ethiopia

*Dr. Yayehyirad Kitaw*

Sierra Leone migrants in the Netherlands: Perspectives on FGM/C, culture and secrecy

*Anke van der Kwaak*

**Discussion**

**2.00-3.00pm SESSION EIGHT: MEDICALIZATION AND TRAINING**

*Chairperson: Dr. Nawal Nour*

**Presentations**

Addressing of the medicalization of FGM

*Dr. Elise B. Johansen*

FGM/C in health training: Guidelines / Curricula

*Dr. Guyo Jaldesa*

**Discussion:**

Knowledge gaps in research and service delivery

*Led by Women and Health Alliance International (WAHA)*

3.00-5.00

**SESSION NINE: COMMUNITY BASED INTERVENTIONS**

Chairperson: *Dr. Heli Bathija*

**Keynote Addresses:**

How community based interventions work

*Dr. Nafissatou J. Diop*

What works and what doesn't against FGM/C: why community based interventions work best

*Dr. Els Leye*

**Roundtable Discussion:**

FGM/C and other health topics: similarities and differences in the usefulness of community interventions

*Professor Violet Kimani, Professor Isaac Nyamongo and UNFPA Representatives*

**Presentations:**

Design considerations for the evaluation of FGM/C Initiatives

*Dr. Ian Askew*

Establishment of an African Coordinating Centre for the elimination of FGM/C

*Dr. Nesrin Varol*

5.00-5.30pm

**CLOSING CEREMONY AND VOTE OF THANKS**

**DAY THREE:**

(By Invitation)

**9.00-11.00am PLANS FOR THE ESTABLISHMENT OF THE CENTRE**

Chairperson: *Professor Isaac Nyamongo*

Proposal for an African Coordination Centre based in Nairobi

*Professor Joseph G. Karanja*

Mobilising International Commitment

*Dr. Heli Bathija*

**Roundtable Discussion:**

Explore the options for an African Centre on research and training in Nairobi

11.30am-12.30pm

**THE WAY FORWARD**

*Professor Christine Sekadde-Kigundu and Dr. Guyo Jaldesa*

